

A brief excursion into critical realism (via the topic of Breastfeeding Peer Support)

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DE CIPHer

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Will cover...

1. Very basic introduction to realist philosophy and why this approach is relevant to applied real world research.
2. Why we need to be cautious about interpreting findings from experimental studies of complex interventions
3. How applying realist principles the experimental studies might help us work out what actually happened
4. How applying realist principles to qualitative data can help us think about causality
5. A opportunity to experiment with the approach



(1) Realist methods – the basics

Some basic philosophy:

Critical realist perspective

What's actually out there?

❖ **Ontological realism**

- There is a real causal world out there
- Human agency interacts with wider context creating processes to bring about change

What can we know?

❖ **Epistemological constructivism**

- The causal processes in the real world are not directly accessible
- They are understood and communicated through constructions (theoretical accounts)
- Constructions will influence attempts to model reality
- Crucially, some constructions will be closer to reality and therefore 'better' (more real)

The job of science...

❖ **To develop increasingly explanatory accounts** (refutable)

- Find the 'best empirically supported account that renders intelligible more phenomena than competing explanations' (Oliver, 2011)

So, for intervention development...

❖ **Interventions are theories** (formalised constructions) about real processes

- Theory may not always be explicit (this is increasingly frowned on – MRC guidance)
- Several competing constructions may have working value
- But some will be better than others and we should try to use those

Realist causality $C+M=O$

(Pawson and Tilley, 1997)

- ❖ **Causality is local, depends on complexities of a specific context (C)**
 - Surrounds to the intervention (social, economic, temporal, organisational, networks, geographical, historical influences – think ecological framework) AND
 - Components of the intervention (participants, staffing, funding, timing, frequency etc)
- ❖ **Underlying processes change the decisions that people make mechanisms (M)**
 - Emotional or cognitive responses that cause people to respond to make stuff happen
 - Mechanisms are triggered in some contexts but not in others
- ❖ **Aspects of context trigger or modify the mechanism to generate outcomes (O)**

CMO's help us understand...

‘what works for whom, in which contexts and how’

So we should look for patterning or demi-regularities for portable explanations of causal effect

(2) Example – what is this thing called breastfeeding peer support?

Defined as ...

‘Training local women to engage with local mothers in a variety of ways through a range of access points’ Dykes, 2005

‘Emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge of a specific characteristic or stressor and similar characteristics as the target population’ *Dennis, 2003*



Hmmm... that's not very specific is it?
I wonder if we are all talking about the same thing?

Variation in intervention design

When does the support happen?

Is support proactive?

Where?
Hospital or community?

For support of
for problem solving?

Group based,
face-to-face or
telephone?

Integration
with health
professionals?

Universal or
targeted?

What length &
status of
training?

Who are the
'peers'?

How much
contact, how
often?

Just
breastfeeding
or formula too?

Supervision
arrangements?

And every intervention context is different ...

High or low background rates?

Are staff stretched to capacity?

Hospital is Baby Friendly?

A priority for local health professionals?

Grandparents look after babies?

Normal to feed when out and about?

Existing peer or voluntary support?

Specific local practices or beliefs?

Views of partners?

Women return to work?

Good prior experience of using lay workers?



dreamstime.com

But: A recent systematic review

(Jolly et al, 2012)

- BMJ well conducted review, 17 studies, exclusivity, continuation
- 4 UK trials (3 included in meta-regression).
- All 1-2-1 models of peer support.

Conclusion: 'Unlikely to work in the UK'

Conclusion: May be too much existing support to



Hmmm. Needs further thought...

(Thomson & Trickey, 2013)

❖ **Policy consequences**

- Threat of disinvestment (used as evidence in policy reviews)
- Not much use as a guide for future intervention development

❖ **Critique**

- Lots of heterogeneity (comparing apples and pears)
- Problems with intervention design (some were completely ridiculous)
- Problems with implementation (not testing the theory, just didn't happen)
- Often starting from a very low base (peer support just one cog...)
- Trials don't represent real world peer support interventions (tend to be 1-2-1 and 'studies' – no time to bed in)

❖ **Recommendation – realist review**

- Get underneath the studies, understand WHY they didn't work
- **Develop theories**
- Transfer theories to other settings based on suitability for that context
- And test theories, not 'peer support', and not intervention components

There's not enough evidence to say 'it doesn't work'

“It is over-simplistic to think of peer support as a single intervention which either works or does not work and which can be evaluated in isolation from delivery context.

The conclusion that peer support is ‘unlikely to be effective’ in the UK seems premature.”

Trickey, 2013

(3) Applying realist principles to experimental studies



Work in progress...

We are applying principles of realist review to fifteen breastfeeding peer support intervention cases. Drawing on process evaluations, training materials, correspondence with the authors...

Aims of the review

1. Articulate BFPS programme theories and map heterogeneity in intervention theory, in wider contextual conditions and in intervention context.
2. Explore the evidence for context-mechanism relationships that either promote or impede receipt of effective BFPS; to identify design opportunities and modifiable weak points to inform future intervention design and implementation.
3. Identify specific context-mechanism relationships associated with experimental conditions that either promote or impede receipt of effective BFPS

Stages of the review

1. Identify cases – fifteen BFPS interventions that had been subject to experimental study.
2. Gather additional information – process evaluations, training materials, secondary analyses, external validity studies, qualitative studies, correspondence with the author. *What was actually going on here?*
3. Detailed data extraction – the goal, the intervention, any explicit theory, any implicit theory, the type of study, what actually happened – observed or inferred or implied – in this particular case.... *Why did it work... why did it not work...*
4. Look across the studies for common patterns ... start to develop ideas about *what works where why and for whom*... look for disconfirming information
5. Develop a set of evidence based propositions and use these to develop recommendations to inform future intervention design

Create detailed case descriptions ...

Included cases: 1-2-1 BFPS interventions intended to improve breastfeeding rates among mothers of full term babies, subject to experimental study

No	Case	Narrative
1	McInnes (2000) UK.	<p><u>The goal:</u> To improve initiation rates and continuation rates to six weeks to women of all parity living in a geographically defined population.</p> <p><u>The intervention context:</u> A low-dose (four contacts) antenatal-postnatal community-based BFPS intervention, delivered by local peers.</p> <p><u>Wider context:</u> High levels of deprivation, very low breastfeeding rates (around 10% at six weeks), no history of voluntary support, health professionals were ambivalent about breastfeeding.</p> <p><u>Embeddedness:</u> Intervention developed alongside study design.</p> <p><u>The theory:</u> Health education and social support implied. Part of a community-wide promotion programme. Used an action-research based design. Homophily strongly intended, peers from the target community and intended as role models. Peers had a child aged under 5, suggesting learning from the immediate personal experience was intended. Peers gave themselves the title of 'helpers', suggesting support was intended to be minimally hierarchical. The intervention was strongly breastfeeding-centric. The training was to enable peers to 'promote breastfeeding and support breastfeeding mothers'.</p> <p><u>CMO relationships</u></p> <ul style="list-style-type: none"> • The wider cultural sphere: Against a background of very low breastfeeding rates (C) an intervention focused on promoting and supporting breastfeeding (C) delivered to a whole population target group (C) was seen as irrelevant by many intended participants who had already made a firm decision to formula feed (M) leading to a high drop-out rate after the initial antenatal contact (O). [Trial study, process evaluation, author inference] • The health care pathway: Ambivalent attitudes to breastfeeding and to the intervention among health professionals (C) and the fact that the intervention did not address care in a hospital setting (C) may have led to mixed messages being received by some mothers (M) [Process evaluation, author inference] • Peer accessibility: The postnatal support did not include in-hospital support (C) in a context of low breastfeeding and high rates of discontinuation (C) many mothers were not contacted in the days after the birth (C), so that a countervailing social norm of discontinuation (M) led to mothers deciding to cease breastfeeding before contacting the counsellor (O). [Trial study, process evaluation, author & reviewer inference] • Inside the peer-mother relationship: An antenatal visit to promote breastfeeding (C) may have encouraged mothers who would not otherwise have done so to consider breastfeeding (M) and/or may led mothers to report intention to breastfeed as a socially acceptable response (M) leading more mothers 'intending' to breastfeed (O) with no impact on initiation (O) [Trial study, process evaluation, author & reviewer inference] • Inside the peer-mother relationship: Breastfeeding mothers (C) felt that their decisions were affirmed and valued by the peer (M) leading to improved self-esteem (O) [Process evaluation, reviewer inference]. • Within intervention feedback: Many participants decided to formula feed (C) leading to peers feel despondent and de-motivated by their failure to persuade (M) meanwhile peers felt valued by the breastfeeding mothers they supported (M) leading peers to direct time above and beyond the intervention protocol towards motivated mothers who were struggling (M) this experience of dissonance (M) led peers to collectively decide to informally adapt the intervention goals and refocus support towards meeting the needs of mothers who wanted to breastfeed (O) [Process evaluation] • Longer term feedback: The peer-led and group based community awareness raising aspects of the intervention (C) led peers to feel bonded to one another (M) re-enforcing commitment to a community activism role (M) leading to an increased community-level breastfeeding support presence (O). [Process evaluation, reviewer inference]. • Longer term feedback: In a context of high levels of deprivation and limited opportunity (C) the experience of training, purposive activity with affirmative feedback from supervisors and colleagues (C) led peers to gain skills and confidence and a sense of being valued (O), potentially improving community capacity for formal and informal support in the longer term [Process evaluation, reviewer inference]. • Longer term feedback: Against a background of low rates (C) the intervention challenged assumptions that women would choose to formula feed (M) leading some health professionals to consider suggesting breastfeeding to more mothers (O) [Process evaluation] <p><u>Outcomes:</u> There was no change in breastfeeding rates. It is not clear whether changes in context were sustained. [Trial study, qualitative study]</p> <p><u>Significant implementation failure?:</u> Yes – there was an informal change in the goals of the intervention leading to reduced focus on 'promoting' breastfeeding to individual mothers antenatally.</p> <p><u>Review team reflection:</u> The goals of the intervention were poorly aligned with the needs of the target population. For future evaluation in such a context a theory of change, is needed to explore any links between intermediate goals (changes in attitudes and beliefs) and changes to the context.</p>

Pull out CMOs within each case ...

The wider cultural sphere:

Against a background of very low breastfeeding rates (C) an intervention focused on promoting and supporting breastfeeding (C) delivered to a whole population target group (C)

was seen as irrelevant by many intended participants who had already made a firm decision to formula feed (M) leading to a high drop-out rate after the initial antenatal contact (O).

[Trial study, process evaluation, author inference]

C – Context

M – Mechanism

O – Outcome

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Pull out CMOs within each case ...

Within intervention feedback:

Many participants decided to formula feed (C)

peers felt despondent and de-motivated by their failure to persuade (M) but valued by the breastfeeding mothers they supported (M)

leading peers to direct time above and beyond the intervention protocol towards motivated mothers who were struggling (O) and to agree to adapt the intervention goals and refocus support towards meeting the needs of mothers who wanted to breastfeed (O)

[Process evaluation]

C – Context

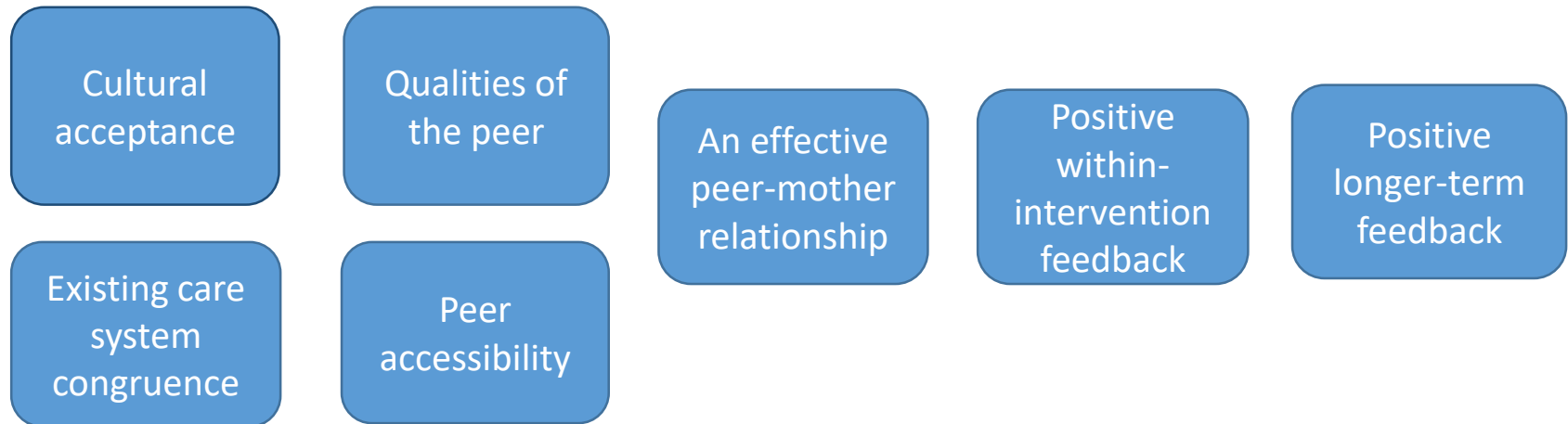
M – Mechanism

O – Outcome

Identify implications for design...

Implications for intervention design:

Good BFPS design ensures active mechanisms which promote ...



E.g. Design - Peer accessibility

Accessibility of the peer	Design implication
If there is a rapid decline in breastfeeding rates soon after the birth, then early contact is essential to success.	Consider in-hospital support, ensure referral pathways - consider <i>local</i> issues of capacity, credibility and logistics.
If the mother is already strongly inclined to formula feed or already motivated to breastfeed antenatal support may make no difference/ be unnecessary.	Consider the pre-existing level of motivation and commitment to breastfeeding within the target population
In any context, mothers have strong social and emotional barriers to seeking help. Reactive support is taken up only by mothers who are strongly motivated to overcome breastfeeding challenges and/or are unusually confident to seek help. Even in these circumstances the mother is unlikely to ask for help more than once.	Use a proactive design.

E.g. Design – Health care pathway

Health care pathway	Design implication
Ambivalent attitudes to breastfeeding among health care professionals are likely to undermine the goals the BFPS intervention	Unrealistic to expect change without addressing rates of in-hospital formula-milk supplementation, health professional attitudes and hospital policies.
Ambivalent attitudes to lay help are likely to undermine the goals of the BFPS intervention	Unrealistic to expect change before an intervention is fully embedded. Address issues of integration and credibility, including role-compatibility and referral pathways.
Unreliable referral to the peer after discharge from hospital is a common cause of implementation failure	Ensure that appropriate and manageable systems of referral are in place, steps to achieve these may be context specific.
Interventions designed for the purpose of experimental study are at risk of implementation failure due to poor embeddedness, low credibility and insufficient integration	Trial in a site where health professionals are familiar with BFPS workers. Consider using natural experiment designs, cross-sectional or observational study methods for outcome evaluation.

(4) Realist analysis of qualitative data



Qualitative data to address causality?

(Maxwell, 2004, 2012)

❖ Many qualitative research text books say 'No!'

- Qualitative research is about Experience, perceptions, beliefs etc... (e.g. King and Horrocks, 2010)

❖ But! Qualitative methods are tools not a philosophical framework

And anyway they are used to look at causality!

- Process oriented qualitative research
- Case studies

❖ Realists use qualitative methods to

- To elicit and develop plausible mid-range theories about causality
- To test theories of causality (through close observation of cases)

❖ What sorts of theory?

- Formal / informal programme theory (what is meant to happen)
- Theories of action (what is understood about what actually happens)

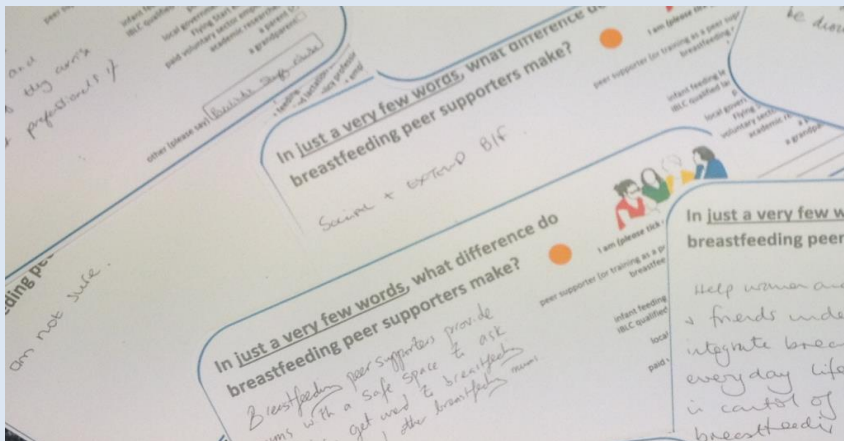
❖ Where can we find theories?

- Policy and intervention documents, research papers etc...
- People's heads Stakeholders, wider public... researchers
- Can be multiple, compatible, conflicting

Why is it
happening?
How is it
happening?

What do we believe about how peer support works?

- Policy documents (6)
- Interviews with professional advocates(17)
- Multi-stakeholder focus groups, parents, peers, health professionals, policy makers (12)
- Interviews with stakeholders in areas with low breastfeeding rates.



Not much formal theory
But plenty of ideas in people's heads!

One approach to realist data analysis ...

1. Code data in terms of statements relating to **contexts (C)**, **mechanisms (M)** and **outcomes (O)**, using thematic analysis methods (categorising)
2. Look for CM, MO or CMO strings in the data using narratives (connective)
3. Look for connections or constellations in different contexts

(Sort of based on... Jackson and Kolla, 2012)

People speak naturally in CMO strings

I think to myself, 'oh wouldn't it be great if we had peers, peers there breastfeeding and supporting other mothers' ... and then I think
'if that girl had argued with a few girls and they've got something in for her,
the fact that she's breastfeeding would be completely...
'well, I'm not doing what she's doing!'

So here the stakeholder's theory is:

- C** – a pre-existing conflict between potential peers in the target community
- M** – mother feels alienated from breastfeeding behaviour of potential peer
- O** – mother decides not to breastfeed

Note **M** is partly inferred

Mechanisms can be multiple ...

‘They’re not just associated with breastfeeding alone, it’s lots of things and they have a giggle about lots of things and the women seem to like the thought of that [...] I think that they [peer supporters] take away the potential isolation even in a town and they fill in the grey areas that books and even professionals because we come from things at a different angle, we’re trying to sort out the problems and we don’t do like the support groups which is we always try and give them the answer instead of helping them to figure things out for themselves’

So here:

- M** – friendships develop between peers
- M** – mothers feel less isolated
- M** – mothers feel they have someone to talk to about the ‘little things’ (grey areas)
- M** – mother feels more capable and confident in her ability to overcome problems


Stakeholders think in terms of outcomes

It's about getting it out there to that wider community, that's going to be influential. Because for every mother that goes out there there's going to be this little bit of uncertainty, I don't think anybody aims to be but if you listen to the mothers [...] somebody has suggested their babies is not feeding enough.

It does full circle because when we've done this it's now the women who come back to me on their second or third babies, these should have, this should have had an impact for the second time around...

Well, to me the change was that it improved knowledge [...] about breastfeeding because they [mothers] might not have had the knowledge base

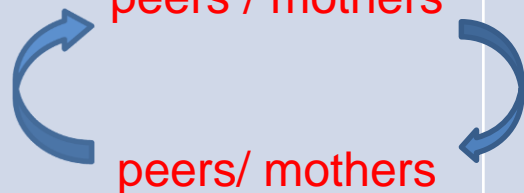
1. Enhancing the care pathway (1-2-1)

MECHANISMS	CONTEXT	RELEVANT OUTCOMES
<p>Mothers</p> <ul style="list-style-type: none"> • Believe that there is help • Trust peer 'expertise' • Overcome 'grey area' issues (e.g. leaking breasts) • Feel listened to and come up with their own solutions • Feel comfortable talking with 'someone like me' • Feel encouraged by drawing on peer supporters own experiences <p>Direction of change: Peer → Mother</p>	<p>Key</p> <ul style="list-style-type: none"> • Integration • Trust bet. HPs & peers • Quality training • Quality supervision • Matching 	<ul style="list-style-type: none"> • Accesses support • Referral pathways • Problems overcome • Feel supported • Enjoy feeding • Change beliefs • Meet their goals • Initiate breastfeeding • Breastfeed for longer


2. 'Mothers and sisters'

MECHANISMS	CONTEXT	RELEVANT OUTCOMES
<ul style="list-style-type: none"> • Socially safe space, breastfeeding is normalised • Vicarious learning • Friendships re-enforce decisions • Alternative beliefs and attitudes to call on, a challenge to negative feedback from an existing social network or health professionals 	<ul style="list-style-type: none"> • Group setting may not be appealing • Groups become infiltrated by middle class mums • Unhealthy group dynamics – cliques • Health professionals feel threatened and withdraw support 	<ul style="list-style-type: none"> • Feel less 'odd' • Feel more confident • Enjoy feeding • Better experiences • Longer durations

Direction of change:
peers / mothers



3. 'Ripples in the pond'

MECHANISMS	CONTEXT	OUTCOMES
<ul style="list-style-type: none"> Consciousness raising - cultural and commercial and health service barriers to breastfeeding, become passionate and want to change the world around them Trained peers take their knowledge out into every day life Mothers want friends and family to have good experiences 	<ul style="list-style-type: none"> If intervention only reaches a sub-community re-enforcing existing differences between women. HPs feel threatened and withdraw support  <p><i>w. Permission via Ella Tabb @Purpleella</i></p>	<ul style="list-style-type: none"> Mothers inspired to train and support others Tell positive stories Become radicalised, change community context Change in beliefs and attitudes of others More women plan to breastfeed HPs feel inspired and 'up their game'

Direction of change:





Your turn!
Choose three
colours...

C-M-O

Using CMO codes... what can the transcript excerpts tell us about the respondent's implicit understanding as to how breastfeeding peer support works (or doesn't)?

What works (or doesn't), where, why, and for whom?

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